

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## CHAPTER II

### PROVIDER PARTICIPATION REQUIREMENTS

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	i
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## **CHAPTER II**

### **TABLE OF CONTENTS**

	<u>Page</u>
Participating Provider	1
Provider Enrollment	1
Participation Conditions	2
Dental Specialists	2
Participation Requirements	2
Documentation of Records	4
Termination of Provider Participation	4
Termination of a Provider Contract upon Conviction of a Felony	5
Reconsideration and Appeals of Adverse Actions	5
Medicaid Program Information	6
Repayment of Identified Overpayments	6
Requirements of Section 504 of the Rehabilitation Act	6
Requirements of the Civil Rights Act of 1964	7
Utilization of Insurance Benefits	7
Exhibits	9

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	1
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## **CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS**

### **PARTICIPATING PROVIDER**

There are two types of participating dental providers: (i) dentists in private practice licensed by the Department of Health Professions and (ii) hospital, state, and federal dental clinics.

The licensed dentist in private practice, whether practicing individually or in a group partnership or corporation, must enroll individually.

Hospital, state, and federal dental clinics must enroll as such. The clinic dentist, whether licensed by the state or temporarily permitted to practice dentistry by the State Board of Dentistry, is directly responsible for the services rendered to recipients.

### **PROVIDER ENROLLMENT**

Any provider of services must be enrolled in the Medicaid/FAMIS Program prior to billing for any services provided to Medicaid/FAMIS recipients. A copy of the provider agreement with instructions on how to complete the forms can be found at the DMAS website ([www.dmas.virginia.gov](http://www.dmas.virginia.gov)) or by contacting the Provider Enrollment/Certification Unit at 1-888-829-5373 (in-state, toll-free) or 1-804-270-5105, or sending a fax to 1-804-270-7027. All providers must sign and complete the entire application and submit it to the Provider Enrollment/Certification Unit at:

First Health  
VMAP-PEU  
PO Box 26803  
Richmond, Virginia 23261-6803

An original signature of the individual provider is required. The Medicaid participation agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement as a result of any name change or change of ownership.

Upon receipt of the above information, a Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	2
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## **PARTICIPATION CONDITIONS**

Any dental provider licensed to practice dentistry in the Commonwealth of Virginia (or in the state in which he or she practices) may apply for participation in the Virginia Medicaid Program by signing the authorized participation agreement. The agreement must be in effect at the time services are rendered in order for them to be considered for payment. Medicaid can pay only for services performed by the participating dentist or persons under his direct personal supervision. Records must fully disclose a sufficient amount of information to indicate the extent and nature of the dentist's overall supervision and participation in the care and treatment of the patient.

### Dental Specialists

To be classified by DMAS as a specialist, a dental provider must be licensed to practice dentistry in the state where treatment is rendered and meet one of the following two conditions:

- Be a Diplomat of the appropriate board recognized by the American Dental Association.
- Meet the minimum board-eligible requirements stipulated by his or her respective board or specialty, which is recognized by the American Dental Association.

## **PARTICIPATION REQUIREMENTS**

All providers enrolled in the Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreement. Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by the Department of Medical Assistance Services (DMAS):

- Immediately notify the Provider Enrollment/Certification Unit at FIRST HEALTH, in writing, of any change in the information, which the provider previously submitted;
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;
- Ensure the recipient's freedom to reject medical care and treatment;
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the grounds of race, color, or national origin;
- Provide services and supplies to recipients in full compliance with the requirements of Section 504 of the Rehabilitation Act of 1973, requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	3
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section in this chapter regarding Section 504 of the Rehabilitation Act);

- Not require, as a pre-condition for admission or continued stay, any period or private pay or a deposit from the resident or any other party;
- Not bill the recipient or Medicaid for missed or broken appointments;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency;"
- A provider may not seek to collect from the Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example, if a third party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative;
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated claim forms and billing invoices for the submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. (Refer to the section in this Chapter regarding documentation);
- Such records must be retained for a period of five years from the date of service or as provided by applicable state law, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (Refer to the section in this chapter regarding documentation for records);
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	4
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

providing any form of health care services to recipients of medical assistance; and

- Hold information regarding recipients confidential. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.

## **DOCUMENTATION OF RECORDS**

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid clients. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and must be legible and clear in the description of the services rendered. The following elements are required:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- For dental visits, the record must contain all radiographs required for the patient's treatment.

## **TERMINATION OF PROVIDER PARTICIPATION**

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FH-PEU thirty (30) days prior to the effective date. The addresses are:

Director  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

First Health – VMAP-PEU  
P.O. Box 26803  
Richmond, VA 23261-6803

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	5
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

DMAS may terminate a provider from participating upon thirty (30) days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

## **TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY**

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

## **RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS**

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (APA) (Section 2.2-4000 et seq.) and the *State Plan for Medical Assistance* provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	6
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## **MEDICAID PROGRAM INFORMATION**

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives Program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request Form is available on the DMAS website, [www.dmas.virginia.gov](http://www.dmas.virginia.gov), or by contacting the Provider Enrollment/Certification Unit at the address below. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

First Health  
VMAP-PEU  
PO Box 26803  
Richmond, Virginia 23261-6803

Phone: 1-804-270-5105 or 1-888-829-5373 (in-state, toll-free)  
Fax: 1-804-270-7027

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

Provider Manuals and manual updates are posted on the DMAS website for viewing and downloading. The web address is [www.dmas.virginia.gov](http://www.dmas.virginia.gov). Providers are notified of Provider Manual updates through messages posted on Medicaid remittance advices.

## **REPAYMENT OF IDENTIFIED OVERPAYMENTS**

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to Section 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

## **REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT**

Section 504 of the Rehabilitation Act of 1973 provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a



<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	7
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with § 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

## **REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964**

All providers of care and suppliers of services under the contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be provided to Medicaid recipients without regard to race, color, or national origin.

## **UTILIZATION OF INSURANCE BENEFITS**

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	8
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

Regardless of whether Medicaid is billed by the provider for rendered services related to an accident where there is a possibility of third-party liability or if the recipient reports a third party responsibility, the provider is requested to complete the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219 (See "Exhibits" section at the end of the chapter for a sample of the form.).

<b>Manual Title</b>	<b>Chapter</b>	<b>Page</b>
Dental Manual	II	9
<b>Chapter Subject</b>	<b>Page Revision Date</b>	
Provider Participation Requirements	1-13-2005	

## **EXHIBITS**

### **TABLE OF CONTENTS**

Mailing Suspension Request	1
Third-Party Liability Information Report DMAS-1000	2



**MAILING SUSPENSION REQUEST  
SERVICE CENTER AUTHORIZATION  
SIGNATURE WAIVER  
PHARMACY POINT-OF-SALE**

**Please review and check the blocks which pertain to you:**

☐ **MAILING SUSPENSION REQUEST:**

I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

☐ **COMPUTER GENERATED CLAIMS:**

I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

\_\_\_\_\_  
(Service Center Preparing Invoices)

**Service center code:** \_\_\_\_\_ **Magnetic Tape RA:** YES NO (Circle One)

Prior service center code: \_\_\_\_\_

☐ **SIGNATURE WAIVER:**

I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**

I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

**PROVIDER NAME:** \_\_\_\_\_

**PROVIDER NUMBER:** \_\_\_\_\_ Leave blank, if number pending.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**TELEPHONE #** \_\_\_\_\_

Please return completed form to:

**First Health**  
VMAP-PEU  
PO Box 26803  
Richmond, Virginia 23261-6803  
1-804-270-5105

